NC DMA Pharmacy Request for Prior Approval - Cialis

Recipient Information **DMA-3485**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Cialis** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

**** Cialis is not covered when prescribed to treat Erectile Dysfuntion (ED)****

1. Is the beneficiary 18 years of age or older? ☐ Yes ☐ No
2. Is the beneficiary male? ☐ Yes ☐ No
3. Does the beneficiary have a confirmed diagnosis of Benign Prostatic Hyperplasia? ☐ Yes ☐ No
4. Is the beneficiary currently receiving an alpha blocker or nitrate? ☐ Yes ☐ No
5. Please list the preferred medications for Benign Prostatic Hyperplasia from the NC Medicaid and Health Choice preferred drug list (PDL) that the beneficiary has tried and failed:

_____

_____

_____

_____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505